# *LOS ANGELES COUNTY COMMISSION ON HIV*

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## JOINT COMMISSION ON HIV/ PREVENTION PLANNING COMMITTEE HIV PLANNING MEETING MINUTES

**October 11, 2012**


| COMMISSIONERS PRESENT | COMMISSIONERS PRESENT (*Cont.*) | PPC MEMBERS PRESENT | PPC MEMBERS ABSENT |
|---|---|---|---|
| Carla Bailey, *Co-Chair* | Mario Pérez | Michael Green, *Gov. Co-Chair* | Scott Campbell |
| Michael Johnson, *Co-Chair* | Karen Peterson | Anthony Gutierrez, *Com. Co-Chair* | John Copeland |
| Al Ballesteros | Gregory Rios/Terry Goddard | Ricky Rosales, *Com. Co-Chair* | Trevor Daniels |
| Cheryl Barrit | Juan Rivera | Sophia Rumanes, *Gov. Co-Chair* | Jeffrey Goodman |
| Vivian Branchick | LaShonda Spencer | Juli-Ann Carlos | Heather Grant |
| Christopher Brown | Carlos Vega-Matos | Michelle Enfield | Brian Lew |
| Lilia Espinoza | Tonya Washington-Hendricks | Aaron Fox* | Victor Martinez |
| Aaron Fox* (JPP Co-Chair) | | David Giugni* | Jill Rotenberg |
| Douglas Frye | | Grissel Granados | Kathy Watt* |
| David Giugni* | **COMMISSION MEMBERS ABSENT** | AJ King | Timothy Young |
| Joseph Green | Sergio Aviña | Milton Smith | |
| Thelma James | Anthony Braswell | Terry Smith | |
| James Jones | Joseph Cadden | Enrique Topete | **DHSP STAFF** |
| David Kelly | Whitney Engeran-Cordova | | Kyle Baker |
| Ayanna Kiburi | Stephen Simon | | Elizabeth Escobedo |
| Lee Kochems | Kathy Watt* | **COMMISSION STAFF/CONSULTANTS** | Claire Husted |
| Brad Land | Jocelyn Woodard/ Robert Sotomayor | | John Mesta |
| Ted Liso/Jim Chud | | Diane Burbie | Cheryl Williams |
| Anna Long | Fariba Younai | Dawn McClendon | Juhua Wu |
| Abad Lopez | | Jane Nachazel | |
| Elizabeth Mendia | | Glenda Pinney | |
| Jenny O'Malley | | James Stewart | |
| Angélica Palmeros | | Craig Vincent-Jones | |
| | | Nicole Werner | |
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| H. Avilez | Luke Klipp | Terri Reynolds | Lambert Talley |
| Cesar Chadra | Gabby León | Daniel Rivas | Brigitte Tweddell |
| Ronald Cortez | Jesse Lopez | Tania Rodriguez | Jithin Veer |
| Camila Crespo | Kiesha McCurtis | Martha Ron | Jason Wise |
| Susan Forrest | Dean Page | Martin Scharff | Veronica Zoleta |
| Marie Francois | | * Indicates dual Commission and PPC membership. | |

**1**. **REGISTRATION**: Registration opened at 8:30 am.

**2**. **CALL TO ORDER**:

**A. Welcome**: Messrs. Johnson and Rosales opened the meeting at 9:30 am. They encouraged members of the Commission and PPC to leave the past behind and engage with their colleagues. They acknowledged that HIV and health care service delivery are facing new challenges of health care reform and managed care, and pointed to the important role of thoughtful community planning in ensuring patients are diagnosed early and brought into care.

**B. Roll Call** (**Present)**:

- *Commission*: Ballesteros, Barrit, Branchick, Brown, Fox*, Frye, Giugni*, Joseph Green, Thelma James, Johnson, Kelly, Kiburi, Kochems, Land, Liso/Chud, Long, Lopez, Mendia, O'Malley, Pérez, Peterson, Rios/Goddard, Rivera, Spencer, Vega-Matos, Washington-Hendricks
- *PPC*: Carlos, Enfield, Fox*, Giugni*, Granados, Gutierrez, King, Rosales, Topete

**3**. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

**4**. **COMMISSION/PPC COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

**5**. **APPROVAL OF AGENDA**:

**A. Agenda Review**:

- Ms. Burbie, Facilitator, said the meeting will begin with presentations on the requirements from outside funders and other stakeholders that both planning bodies must fulfill. Mr. Brown would then discuss how Chicago integrated prevention and care planning.
- She urged Commission and PPC members to bring their best thinking to craft questions that most need to be addressed. The speaker may not have the answer, but raising it can prompt collective engagement.
- The Benefits and Barriers session on the agenda provides space for the body to set criteria for a joint structure and address realistic, long-standing, practical ways to ensure that identified concerns can be addressed in the new configuration.
- Ms. Burbie asked all to evaluate issues by: Do the parameters allow us the creativity to do what we think is best?

**MOTION 1**: Approve the Agenda Order ***(Passed by Consensus)***.

**6**. **COMMUNITY PLANNING REQUIREMENTS**:

**A. HRSA Ryan White Part A Planning Councils**:

- Mr. Vincent-Jones noted guidelines for the two bodies from: Health Resources and Services Administration (HRSA) Ryan White (RW), the CDC and the County Code (Ordinance), which is the Commission's local authorizing legislation.
- RW, administered by HRSA, is the governing legislation for most Commission work. HRSA prepares guidance for implementing RW legislation and adjusts it per any changes when RW is authorized/reauthorized every five years, as is expected in 2013. It takes two to three years for HRSA to update guidance if changes are significant.
- The Commission is the RW Part A HIV Health Services Planning Council (PC) requiring knowledge of RW legislation and HRSA guidance. It also has less defined responsibilities under the County Ordinance, County Code 3.29.
- RW legislation is fairly prescriptive about PC responsibilities in some areas, but is silent in others. HRSA guidance is more prescriptive in more areas, but leaves some ambiguity in other areas.
- HRSA requires PCs to: establish PC operations, assess the Eligible Metropolitan Area's (EMA's) HIV/AIDS service needs consistent with HRSA direction, set priorities for allocation of funds, develop a comprehensive care plan and assess efficiency of the administrative mechanism. The County chose to do a Comprehensive HIV Plan (CHP) which combines care and prevention. Legislation refers to a "comprehensive care plan" and HRSA guidance to a "comprehensive plan."
- HRSA also expects PCs to: maintain full and meaningful participation of PLWHA, more specifically consumers of Part A services; recruit and train members; develop grievance procedures; and manage conflict of interest.
- PC responsibilities addressed in the annual RW Part A application are:
  - Continuum of care and participation with the grantee (DHSP in the County) on service coordination;
  - How the PC did the Assessment of the Administrative Mechanism (AAM) and followed-up on recommendations;
  - PLWHA consumer involvement such as the Consumer Caucus developed to improve involvement;
  - How Minority AIDS Initiative (MAI) funds are spent and needs of special populations are addressed;

  - What the priority- and allocation-setting (P-and-A) process was and what decisions were reached;
  - How the PC plans Testing and Linkage to Care, Treatment Plus (TLC+)/Early Identification of Individuals with HIV and AIDS (EIIHA)/unmet need;
  - Cost-effectiveness/outcome evaluation efforts;
  - PC letters of assurance on allocation of funds per PC allocations and concurrence on spending per PC allocation;
  - Conditions of Award (COA) such as compliance of membership with RW and HRSA rules and others as determined.
- The PC's first major responsibility is comprehensive care planning, which must include a plan for organization and delivery of services, reflect the community's vision/values and guide HIV service decisions. California, Los Angeles and other jurisdictions are moving faster than HRSA in making comprehensive HIV plans living documents for the local jurisdiction. That creates some tension in striking a federal-local balance. The Commission's CHP was submitted this year. Plans must be updated every three years, but the requirement is likely to end after 2013.
- The second major responsibility is Needs Assessment (NA). It describes services needed, what populations need what services, establishes methods to obtain community input and is the basis for planning and P-and-A. The Commission's NA is the biennial Los Angeles Countywide HIV Needs Assessment (LACHNA) which is a formalized, scientifically methodological way of collecting input from consumers.
- Many find P-and-A the most significant responsibility. The Commission uses an annual, five-month process. It first prioritizes which services and service categories consumers in our system need most with LACHNA providing key data.
- Allocations for each service the PC chooses to fund are based on prioritization, cost effectiveness, service utilization data and quality of service. RW is also supposed to be funding of last resort so other funding sources are considered, e.g., the PC has significantly increased oral health care funding since the state cut Denti-Cal a few years ago.
- Each jurisdiction does P-and-A differently. Many use a one- or two-day process. The Commission once did that, but found it dysfunctional as disagreement with the base set of decisions undermined later ones. The Commission's five-month process allows the Priorities and Planning Committee (P&P) to bring each major stage of P-and-A decisions to the Commission for review, any revisions and approval, providing a good basis for the next step.
- Other RW or HRSA planning responsibilities are: MAI, which is now allocated to oral health care, the new Linkage to Care (LTC) and the new Medical Care Coordination (MCC); review financial expenditures to ensure they follow allocations; incorporation of LTC and access to care, which spurred MCC development; EIIHA; and unmet need, i.e., people who have fallen out of care or are unaware of their status. Requirements to address LTC and EIIHA informed the Commission's decision to move to a joint prevention and care CHP, as did unmet need, which has lost some emphasis to LTC and EIIHA efforts.
- RW and HRSA require PC membership to be "reflective," which pertains to consumers. One-third (33%) of sitting PC members must be unaffiliated (also referred to as "non-aligned) consumers, defined by HRSA as those accessing Part A services, who are not affiliated with an agency. There is some controversy between PCs and HRSA on whether consumers must be accessing core medical services, but that is not required to date. The Commission has defined unaffiliated as not staff, consultants or on the Board of a Part A agency, i.e., not in a position of authority, consistent with HRSA guidance.
- Further, total membership and the subset of unaffiliated consumers must each reflect the ethnic and gender make-up of the local epidemic, e.g., in Los Angeles County approximately 45% must be Latino and 11% women.
- RW and HRSA require at least one PC member representing each of 15 categories, such as mental health/substance abuse providers and a local public health agency. The Commission meets some requirements with designated seats and others among the overall membership.
- Four cities must also be represented as they are Local Health Districts (LHDs) or represent 10% of the local epidemic. LHDs are Pasadena and Long Beach. Those with 10% of the epidemic are Los Angeles, West Hollywood and Long Beach.
- RW and HRSA require openness and transparency, i.e., open and public meetings that are recorded with recordings available to the public and minutes. The California Brown Act also requires openness, but not all states have such laws.
- RW and HRSA also require an open nominations process. It is not detailed, but must be open and transparent. Two candidates per seat is preferred, but it is understood that is not feasible with seats such as for the City of Los Angeles. The Commission has a formal nominations process and policy that has been reviewed and approved by HRSA.
- The "Administrative Mechanism" is the complex of partners and policies that administer RW locally including the PC; the Chief Elected Official, Chair, Board of Supervisors (BOS) in Los Angeles County (LAC); the administrative agency, DHSP in LAC; the grantee, Department of Public Health (DPH) in LAC; and sometimes combined provider efforts.
- The AAM assesses effectiveness of funding disbursement, rapid use of funds, procurement process and other pertinent factors. The Commission's recommendations may be directed to the PC or any partner.

- Normally, the AAM is annual, but it has been suspended for a few years to address state budget cuts and existing recommendations. The process was also revised because full annual AAMs tended to replicate each other. The new process alternates a comprehensive AAM one year with a topical AAM the next. An AAM is planned to start in 2013.
- Other operational duties are: PLWHA participation/mobilization addressed via the Consumer Caucus; development of a Comprehensive Training Program (CTP), CTP format completed with curricula in development; public awareness to promote service availability is encouraged and options have been discussed such as a service referral network; By-Laws development with HRSA review/approval; and Conflict of Interest policy, also with HRSA review/approval.
- The PC is responsible for the continuum of care which the local jurisdiction now considers the continuum of care and prevention. It is the blueprint for the local service delivery system and must be addressed in the comprehensive plan.
- The PC has been directly responsible for development of Standards of Care (SOC) for the last five years. Prior to that HRSA did not define the responsible party, but the Los Angeles Project Officer urged PC responsibility which is now in guidance. SOCs define minimum expectations for services to which funds can be allocated. They may include outcomes and best practices which the Commission has set aside as a separate process. SOCs must comply with HRSA service definitions, national guidelines and national outcomes, but may exceed them. DHSP requirements may exceed SOCs.
- RW and HRSA assign quality assurance responsibility to the grantee, but with some duties for the PC such as SOCs and some for joint responsibility, e.g., Evaluation of Service Effectiveness (ESE), outcomes evaluation, cost-effectiveness and best practices. Both the PC and grantee must have a grievance policy/procedure. The PC addresses grievances that are system-wide, e.g., on the decision-making process, or about the service category, e.g., not meeting SOC minimum expectations. The grantee addresses provider/agency grievances on procurement or direct services.

**B. CDC HIV Planning Guidance**:

- Dr. Michael Green reported the Centers for Disease Control and Prevention (CDC) has eliminated requirements for community planning and streamlined recommendations for HIV planning in general.
- The CDC began discussing revising the Community Planning Guidance attached to the Cooperative Agreement three years ago. The Cooperative Agreement ended a year ago, but no guidance accompanied release of the new Flagship Agreements. The CDC released the HIV Planning Guidance in March 2012 with "Community" cut from the title.
- The CDC is closely wedded to the National HIV/AIDS Strategy (NHAS) and framed the Guidance around NHAS goals and objectives as well as what the CDC has termed High Impact Prevention (HIP). For the first time, the CDC did some of the work previously done at the community level, i.e., splitting interventions into those required for CDC HIV prevention funding and recommended interventions similar to HRSA's delineation of core medical and support services.
- The purpose of the Guidance through NHAS and HIP is to ensure HIV planning is efficient and focused on results-oriented processes; encourages collaboration and coordination across HIV prevention, care and treatment services; engages a broader group of stakeholders; and focuses on streamlining communication and coordination among Health Departments (HDs), HIV Planning Groups (HPGs) and community stakeholders to ensure implementation of a full spectrum of HIV prevention services including HIV care, treatment, mental health and substance abuse treatment.
- It is notable that the CDC is fully adopting comprehensive HIV planning in concert with similar HRSA efforts. CDC took the first real step in this direction with Enhanced Comprehensive HIV Prevention Planning (ECHPP) two years ago. To conduct such planning, care and treatment voices are needed on the prevention side and vice versa.
- The CDC believes prevention planning is best handled at the smallest jurisdictional level to access local knowledge about needs and priorities. HIV planning should improve prevention programs by strengthening the scientific basis for planning with evidenced-based interventions; continuing strong community relevance; and increased involvement of key stakeholders including those receiving services, but also practitioners, researchers, economists and HD planners.
- CDC emphasizes a population- or risk-based focus of HIV prevention interventions in each project area. Part of that is realized through its distinction of required from recommended interventions, e.g., requiring Prevention For Positives.
- The CDC also emphasizes communication and coordination of services across the continuum of prevention, care and treatment. The PPC gained experience with this through ECHPP and most recently through the CHP Task Force.
- Fundamentals of HIV planning continue to include Parity, Inclusion and Representation (PIR) with a participatory and collaborative process to ensure key stakeholders, communities, tribal, governmental and non-governmental agencies dialogue with the HD in development/implementation of the Jurisdictional HIV Prevention Plan to reach NHAS goals. Key stakeholder and community participation should be actively sought, but is not prescribed by CDC as HRSA does.
- Similarly, the local jurisdiction is permitted to develop its own plan for by-laws, membership recruitment and training. HPG membership nominations should be solicited via an open process and selection based on criteria established by the HD and HPG. Meaningful participation is stressed as key to jurisdictional plan success and the HIV planning process.

- HPGs must adopt a HIP approach to HIV prevention activities while relying on the most current epidemiological surveillance and evidence-based data. The five HIP components are: effectiveness and cost; feasibility of full-scale implementation; coverage in the target population; interaction and targeting of interventions; and emphasis on interventions with the greatest overall potential to reduce HIV infections.
- The new Guidance differs from previous Guidance in supporting CDC's HIP approach to prevention programs, interventions and research. It also establishes an engagement process with community members, key stakeholders and service providers who can best inform their jurisdiction's HIV prevention priorities. HPGs are now asked to describe and concur with the planning process undertaken by the jurisdiction. Previously, HPGs defined priorities.
- The new Guidance defines CDC's expectations for HDs and HPGs in implementing HIV planning and provides new requirements to monitor the process. There are new objectives for the HIV planning process that accurately reflect the specific processes and activities now required. The process is streamlined to support expanded partnerships and a coordinated local prevention/care/treatment response to achieve NHAS goals.
- The CDC grants the jurisdiction authority to develop the most comprehensive HPG possible and determine HIV planning processes, e.g., membership, how often to meet, goals and objectives. It does require the HPG to concur with the plan and requires proactive engagement with other relevant federal planning processes especially HRSA, Substance Abuse and Mental Health Services Administration (SAMHSA) and Housing Opportunities for Persons with AIDS (HOPWA).

**C. County Code 3.29 (Ordinance)**:

- Mr. Vincent-Jones said the Los Angeles County Charter or "Code" is the set of laws under which LA County is organized. The BOS acts as a combined executive/legislative branch. Laws passed by the BOS go into the County Code. The Commission has been in the Code since it was founded by merging two earlier planning bodies.
- Because the County Code is law, the Commission's authority and legal obligations are derived from it. Most LAC commissions that are significant—that have any level of authority or interaction with the Board—have some type of County Code governing their operations either as part of general commission County Code or with their own.
- Title 3 of the County Code deals with commissions/advisory bodies, with Chapter 29 on the Commission on HIV. Most commissions have a sunset review every four or five years to justify their continued existence; the Audit Committee of performs the sunset review and makes the revisions if needed. There have been three Commission revisions since 2001 with a major one when the Commission separated from the then Office of AIDS Programs and Policy (OAPP) in 2004 and one last year.
- Section 3.29.020 reflects how the Commission meets membership requirements and needs. There are six required seats for government institutions: Medi-Cal; the State Office of AIDS, Part B administrator; and the four cities noted earlier. Five seats are required to represent RW Parts since Los Angeles County has grantees for each: A, LAC DPH; B, LAC DPH; C, grantee; D, grantee; F, local medical schools, AIDS Education Training Centers (AETCs) and/or dental providers.
- There are 14 unaffiliated consumer seats: 8, one per Service Planning Area (SPA); 5, one per Supervisorial District; and one At-Large. Another is needed if there are no vacancies, as 33% of the total 45 seats must be unaffiliated consumers. There are two in other seats now. Such consumers must reflect local epidemic ethnic and gender demographic ratios.
- There are 8 providers with one from each SPA. Representation requirements are: AIDS Service Organization (ASO), social service provider, mental health provider, substance abuse provider and an organization offering other federally-funded HIV services. Geographic diversity is provided by having one provider per SPA, but is not required.
- One HIV medical provider is required for representation. The Commission requires that seat to be filled by an HIV specialty physician because there has been a gap in physician representation on the Commission in the past.
- There are five general Supervisorial District representatives and one seat each for: a health care system serving people with HIV, required; PPC; DHSP; Department of Health Services (DHS); LAC HIV surveillance; and another LAC department. The DHS and other LAC department seats were added last year to ensure good LAC representation to address implementation of the Affordable Care Act (ACA). An unaffiliated consumer seat was also added to maintain the 33%.
- Sections 3.29.040 – 3.29.45 address alternates and nominations. Any Commissioner who is HIV+ and has publicly disclosed his/her status has the right to an alternate. Originally, HRSA allowed alternates to ensure a voice at the table should a member become ill. HRSA is backing away from alternates due to improved health outcomes and a Special Condition of Award asked the Commission to reconsider their use. The Commission supports alternates both because some Commissioners will continue to have health issues, but also because it is a good leadership development opportunity, offer consumers an opportunity to learn about the Commission before they become full Commissioners.

- The nominations process is well developed in Commission policy. All new candidates are interviewed and renewals have a separate process that assesses performance. The process is consistent with RW and HRSA requirements.
- Section 3.29.046 addresses conflict of interest. All members may participate in P-and-A regardless of their potential employment at funded agencies. Members may not advise the grantee about the administration or funding of particular agencies. The Ordinance mirrors California conflict of interest, which says it must be a financial conflict.
- Conflict of interest is of particular concern to RW so a separate policy is required. HRSA has other concerns especially about providers participating in the allocation-setting process since they may benefit from specific allocation decisions in future. The Commission resolved this concern by voting allocations as a whole and by members stating all conflicts prior to voting.
- Sections 3.29.050 – 3.29.060 address term of service, meetings and committees. All members serve at the pleasure of the BOS. Term of service is two years, but membership may begin mid-term. The Ordinance bars members from serving more than two consecutive terms, but the BOS routinely waives the limit. The BOS is advised of attendance biannually and may terminate a member for excessive absences. Members must serve on at least one committee.
- The BOS may also appoint "community" members directly to committees and has appointed Dr. Davis to SOC and Messrs. Fox and Wise to Joint Public Policy (JPP).
- Sections 3.29.070 – 3.29.080 address procedures and compensation. The Commission must adopt By-Laws which incorporate policies and procedures. There is no compensation for service, but consumers may be reimbursed for such expenses as travel outside the jurisdiction. The Commission is developing consumer stipends with the Executive Office.
- Section 3.29.090 addresses duties. The first three were revised last year to be more consistent with RW and HRSA language and Commission practice: A. "Comprehensive plan, continuum of care and standards of care for organization and delivery of HIV care treatment and prevention services"; B. Planning responsibilities such as P-and-A, review of grantee's allocations/expenditures for consistency with Commission decisions, provide/monitor directives on best meeting need and other factors; and C. Evaluate service effectiveness and efficiency of the administrative mechanism.
- The remaining four have been in force for at least 12 years with only language updates such as replacing OAPP with DHSP. These are: D. "Study, advise and recommend" to BOS, grantee and other departments "on matters related to HIV/AIDS;" E. "Make reports to" those bodies on HIV/AIDS-related matters referred to the BOS; F. "Act as the planning body for all HIV/AIDS programs in the DPH or funded by the County;" and G. Make recommendations to those bodies on allocation/expenditure of funding other than RW, but expended by the grantee or County for HIV-related services.
- Section 3.29.095 addresses the grievance procedure as required by HRSA and previously discussed.
- Sections 3.29.100 – 3.29.110 address the commencement date, based on last revision, and sunset review date. The latter is an extensive process required for most commissions. The Auditor-Controller, CEO and Board Offices waived PC review as current RW legislation requires a PC, but review may be required again after 2013 RW reauthorization.
- The Commission on HIV is part of the Executive Office of the BOS, which is its administrative office. As such, the Commission reports directly to the BOS. DHSP is part of the Department of Public Health (DPH) which reports to the BOS. Consequently, many subjects addressed by the Commission pertain to County intergovernmental matters.
- The Commission has five standing committees: Executive, Joint Public Policy (JPP), Operations, Priorities and Planning (P&P) and Standards of Care (SOC). The Executive Committee is composed of the two Commission Co-Chairs, co-chairs of the other committees, three elected at-large members and Mr. Pérez as grantee and the Director of DHSP. Standing committees are established per the By-Laws and, in some cases, the Ordinance.
- There are also a variety of caucuses, task forces and other working groups as defined in Commission policy. Most are topically related and are formed or disbanded per need. The Consumer and Latino Caucuses are viewed as ongoing.
- The Commission must comply with the Brown Act per RW, HRSA and state requirements as well, as its Code of Conduct.

**D. Questions and Answers**:

- Ms. Burbie asked Mr. Vincent-Jones and Dr. Green whether they thought regulatory parameters of a joint body would allow the resulting body the creativity to do what the members think is best. Dr. Green said the CDC has no requirements for the planning body's composition or membership. HRSA does, but he felt those requirements could be met while still allowing complete integration of the prevention planning process with minimal difficulty.
- Mr. Vincent-Jones said he had supported a joint planning body for some time. Now he felt it necessary. HIV services now emphasize joint planning such as EIIHA and ECHPP. He felt it no longer possible to conduct effective planning in silos. HRSA requirements can be met with creative thinking. The most challenging will likely be membership, especially

33% consumers, but that voice is critical. Seats can be adjusted/added during revision and existing members often choose to retire during revision. We are not alone. Four jurisdictions have called about this subject in a month.

- Regarding PPC structure, Dr. Green said it was suspended to work on the Comprehensive HIV Plan, but previously it had two committees: Internal and External. The PPC can change its By-Laws at any point to support any desired structure.
- Mr. Chud asked for LTC clarification. It was discussed at the United States Conference of AIDS (USCA) both as bringing clients to appointments and as bringing new people into care. Mr. Vincent-Jones said the new SOC will combine several existing service categories into a one LTC SOC including Treatment Education, Outreach, redefined Early Intervention Programs and Transitional Case Management. There will be two days of Expert Review Panels in December 2012, which will also look at other models such as Peer Navigation so all forms will be addressed.
- On whether a new body would need an Ordinance, Mr. Vincent-Jones said the Commission has an Ordinance because it reports to the BOS and interacts with other departments as part of that. The Ordinance is the institutionalized format for such activity. The PPC reports to DHSP. He felt the proposed new body would benefit from the Commission reporting structure and noted the Ordinance could be revised, probably within six months, to accommodate it.
- He added the County sees an Ordinance as saying the least with the broadest language to reduce too frequent revision. A desire to involve other planning bodies in future can be addressed via language especially pertaining to duties.
- Terry Smith supported the concept of bodies working together, but details concerned him especially representation of those most impacted, e.g., youth, especially young black and brown men, transgenders and women. Dr. Green felt structure less a deterrent than operational choices, e.g., meeting in the afternoon, meeting sites and a formal meeting structure. Mr. Vincent-Jones added the Commission developed other inclusion approaches, such as the Latino Caucus.
- Mr. Pérez felt Commission-PPC integration did not go far enough, e.g., research shows PLWHA are much more likely to thrive with stable housing yet the City of Los Angeles has struggled to manage it effectively with a siloed approach for 20 years. He felt there may now be a political appetite to plan across the continuum to include working with the Los Angeles Countywide HOPWA Advisory Committee (LACHAC) and the Los Angeles Housing Department (LHD).
- DPH integrated HIV and STD responsibilities into DHSP about a year ago, but he continues to struggle with the lack of a robust STD response for the 60,000 people with STDs. There is poor synergy with HIV as well as with Hepatitis and TB.
- He acknowledged some constraints, but urged thinking about the next iteration of RW as an opportunity to plan comprehensively. There are multiple bodies absorbing time beyond the Commission and PPC such as the ECHPP Scientific Advisory Committee, Medical Advisory Committee and LACHAC.
- Mr. Kochems agreed such voices along with those from quantitative, qualitative, social, behavioral, medical, biological and epidemiological research should be included, but felt they can be engaged without specific member seats.
- Mr. Vega-Matos urged keeping the day's focus on the overall direction and vision of the integrated planning process rather than the details. The level of trust in openness and transparency has grown between the Commission and PPC over the years, but structural barriers remain. Substance abuse and mental health should also be part of planning.
- Ms. Mendia said developing a comprehensive resource inventory and gaps analysis has always been a County challenge. Managed care makes that more complex as would addressing other services mentioned, such as housing. She asked how the P&P Committee would address HRSA funding directives versus CDC and other resource advisements. Mr. Vincent-Jones said he had not addressed solutions as the process will do that, but there are many options.
- Regarding data-sharing with other LHJs, Ms. Barrit said the City of Long Beach works collaboratively with the County on HIV and STD data-sharing and provides regular Commission updates. The Long Beach Comprehensive HIV Planning Group continues to meet quarterly and absorbed the Service Planning Network for SPA 8 when funding was cut.
- Ms. Palmeros noted the City of Pasadena is much smaller, but also works closely with the County to share HIV and STD data. Public Health has had integrated HIV and STDs for some time and is trying to identify additional funding for STD prevention and treatment. Recently it also integrated substance abuse and mental health components.
- Mr. Johnson noted Commission and PPC membership is personal as many have long been at the table. He urged all to come to the process seeking the best for the County. He was on the state planning body when it restructured, but resigned when he saw other skill sets than his were needed. This new body will need skill sets for complex planning involving data and multiple health systems. It is honorable to step aside if others can meet those needs better.

**8. BEST PRACTICES FOR JOINING PLANNING BODIES**:

**A. The Chicago Example**:

- Mr. Brown, Director, Health and Mental Health Services, LA Gay & Lesbian Center; Commissioner; and previously, Assistant Commissioner, STI and HIV Division, Chicago Department of Public Health (CDPH); presented on Chicago's

process to integrate their bodies. The presentation was prepared by Hannah Anderson, 312.745.0437, hannah.anderson@CityofChicago.org. The Chicago Area HIV Integrated Service Council (CAHISC) was adopted in May.

- He stressed starting with an inclusive process since there will be in-depth discussions on all the issues raised today.
- Chicago, like Los Angeles, had had discussions on integrated planning bodies for years. The release of NHAS, ECHPP and the 12-Cities Project acted as a catalyst. Chicagoans who had been involved with national policy energized the effort.
- Chicago had three planning bodies: the Ryan White Planning Council (PC), appointed by Mayor, but located within CDPH; the HIV Prevention Planning Group (HPPG); and Connect-2-Care (C2C), which focused on LTC.
- The process began by engaging all three bodies in a discussion of NHAS, ECHPP and the 12-Cities Project, how they linked together and how it was no longer feasible to silo prevention, care, treatment, surveillance and housing. Many asked if funders were mandating integration. They are not, but separate planning for integrated services is not feasible.
- Chicago decided to integrate planning for prevention, housing, care and treatment. There were also significant discussions about substance abuse. The goal was to coordinate across all systems. There were major challenges with data as the various systems were not integrated so data integration became a key goal.
- The process began with the three bodies and other stakeholders were brought in throughout the process.
- Once buy-in had been obtained, the first step was to suspend annual recruitment which had begun for the bodies. Everyone on the existing bodies was retained since they were knowledgeable about the existing structures.
- The first working meeting is listed as 6/27/2012, but discussions with body members and stakeholders began much earlier. Stakeholders included consumers, former body members, the CDPH, the Mayor's Office and others.
- The PC originally had 52 members, the HPPG had 35 and C2C had 20. Despite overlap, there were some 90 people so it was apparent that was not manageable. The final model had 41 members. It started with 2 alternates, but that was increased to 10. Alternates attend meetings, but only sit at the table if a member resigns or is removed.
- Co-Chair structures for the existing bodies differed. The final structure uses a Community Co-Chair, a Government Co-Chair and a Community Co-Chair Elect who works with the other two and steps in the following year.
- Principles of Parity, Inclusion and Representation (PIR) were embodied through involvement of community leaders, the CDPH, PLWHA, providers from all service categories to ensure RW did not overshadow prevention or housing, liaisons and affiliations. Federal mandates, RW law and grantor requirements were very important.
- Key products are: one comprehensive prevention, care and housing plan; Priority-Setting and Resource Allocation (PSRA) for prevention, care and housing; NA/Gaps Analysis (GA) for prevention and care, housing and other HIV support services; evaluation/quality management (E/QM); letters of concurrence for prevention and assurance for RW.
- An Ad Hoc Committee was formed to address the multiple questions involved. It was comprised of members from the three bodies, providers from all arenas, evaluation/quality management representatives, PLWHA and CDPH.
- The Ad Hoc Committee researched approaches to varying funding cycles, key products, the structure, by-laws and governance, membership criteria and development of a timeline. The only existing models were from states.
- Key issues were varied funding cycles for the $40 million in RW, CDC and the Department of Housing and Urban Development (HUD); varied geographic regions with the HPPG region of the City of Chicago, the PC 9-county EMA region and the HUD 8-county region; how to continue simultaneous work and membership. The latter was especially sensitive and it was decided to dissolve both bodies. Some re-applied. Others made way for new members. A selection committee was used to form the new body using a spreadsheet of requirements with HRSA the most concerned.
- Chicago had provided $50 stipends targeted to PLWHA for participation and many wanted those maintained. Other concerns were meeting schedules, committee structures, mentorship and non-voting ambassadors for expertise.
- The Gardner Treatment Cascade is driving discussions on the HIV continuum of services and the need to plan across it.
- Four options were developed with two, linked options approved. Option 1 was an 18-month pilot including evaluation and assessment with an expressed goal to transition to the final structure later designated as Option 2. Mr. Brown felt Chicago now regrets this phased approach. It was chosen largely as housing was new to the table and needed time.
- Option 1 utilizes a Steering Committee with divisions for Prevention, Care, Housing and Member Services. The first three have committees for NA/GA, E/QM and Priority Setting. Member Services include governance, outreach and capacity building. Chicago has a challenge with this model as services are still siloed, but coordination is better.
- Ultimately, Chicago will transition to the final model. The Steering Committee will coordinate NA/GA, E/QM and Priority Setting committees with each addressing prevention, care and other services. Member Services stays the same.
- A key goal is to ensure committees include one-third each prevention, care and housing members and include consumers. All committee members discuss all subjects, i.e., care representatives do not only discuss care.
- This two-step process had to be approved by the PC Steering Committee, the HPPG Executive Committee, working committees and eventually both full bodies. Community champions with national experience were key in educating the

community, the CDPH and Mayor's Office. HRSA required a formal presentation, while the CDC and HUD were less demanding.

- A Selection Committee for the new body was formed once the model was approved and before the existing bodies formally voted to disband. Identifying members for the Selection Committee itself was challenging. Those who wished to apply for the new body were excluded, but members needed to be knowledgeable and respected by the community.
- HRSA required interim By-Laws between disbanding the existing bodies and initiation of the new body in May 2012.
- Integration core principles are transparency, inclusion, feasibility, accountability and, especially, respect.
- The actual process took well over a year though there had been five years of discussions. Community and stakeholder engagement was key especially via community champions. An interim process and Ad Hoc Committee were necessary to flesh out details. Research on what others were doing and flexibility to adjust were important to development.
- Mr. Brown said housing had not had a formal planning process and has challenges. HUD is not requiring this planning.
- Dr. Frye asked if the pilot was a mistake because it was siloed or a pilot. Mr. Brown said continued silos are the issue.
- Mr. Liso reported biannual mandatory education for management and administration is beginning on how to address those with HIV, diabetes and other disabilities. It is required for funding. Mr. Brown agreed housing is critical.
- Ms. Rumanes asked about dissolution of existing bodies and initiation of the new. Mr. Brown said key concerns were the nearly 100 members of existing bodies, lack of housing representatives and the desire to bring in new people.
- Mr. Land asked how trust was established and key people identified. Mr. Brown said conversations prior to the process included key, trusted community members. These provided leadership at the table when formal discussions began.
- M. Goddard asked if housing focused only on HOPWA. Mr. Brown said the AIDS Foundation of Chicago has a Service Providers Council (SPC) which reviews the larger portfolio of PLWHA housing. The focus was on HOPWA, mid three-year cycle and in need of updated planning, but there was also coordination with the SPC Housing Committee.

**B. State of California Experience**:

- Ms. Barrit, Manager, Preventive Health Bureau, Long Beach, and State Comprehensive Planning Group (CPG) member said leadership was key in her experience including at government agencies involved, planning group(s) and of the selected co-chairs. Terms of engagement, the atmosphere of discussions, should be defined up front.
- It is critical for the purpose to be clear, e.g., passionate discussions occurred on whether this was planning or advising.
- The CPG has a three-year term of service with option to renew. She supported a long term of service, especially for the inaugural body, to ensure familiarity with the people and issues when deciding rules of engagement. She urged time allocated to develop the planning body as a team especially to address bold initiatives like engaging STDs and housing.
- Community voices should be captured not just by being at the table, but by being a strong voice in the process. There also is a fine balance between voices at the table and needed skills. Acknowledge that some voices are likely to be lost and that no individual member will have all of the needed skills so the full body will be needed to move forward.
- It is a journey and there should be space to check in so everyone is on the same page. Each member should work on learning about areas outside their expertise, e.g., those with care experience need to learn about prevention.
- Ms. Kiburi, Chief, HIV Care Branch, Office of AIDS (OA) and CPG Government Co-Chair emphasized the import of broad leadership representation. The CPG had two community and two government co-chairs. It was the first attempt to de-silo OA which is an ongoing process. Community co-chairs were critical in community communication.
- The content of the plan was informed primarily through source documents, e.g., NHAS, the OA Strategic Plan, incorporated goals and objectives within the Prevention and Care Branches, the Health Disparities Framework and the Epidemiological Profile. Various work groups reviewed governance, NA and membership, but ended with NHAS goals.
- The original architecture and table of contents was developed by the previous division chief. This was reviewed when leadership changed. The architecture changed somewhat though has remained mostly the same.
- Ms. Kiburi and Ms. Barrit agreed the state travel ban handicapped the process. Ms. Kiburi also stressed the import of diverse voices at the table and, if not there, then in other ways. A stronger HOPWA voice would have been helpful.
- Mr. Chud asked about OA's relationship to HOPWA. Mr. Kiburi replied OA receives a federal grant and administers about 23 local grants. Shelley Vincent is the primary specialist.

**C. Follow-Up**:

- Ms. Burbie complimented the dialogue. She noted, with both bodies present, there is an opportunity to develop a litmus test to use in developing a restructured way of being going forward. It is important to identify specific goals for the day.

- Mr. Gutierrez said various people have spoken on aspects of a body such as membership but, in terms of process, he recommended first determining consensus for moving ahead. Then it will be appropriate to determine what to do and how.
- ➲ There was consensus to move forward in forming a unified body.
- ➲ There was consensus that a separate group will deliberate on the new structure while today's body would set parameters for the rules of engagement to develop a successful, inclusive, representative and responsive body.

**9. BENEFITS AND BARRIERS**:

- Ms. Burbie said the information on ordinances, funder guidance, lessons learned from other jurisdictions and transition processes would inform the day's work in identifying benefits and barriers to be addressed in creating a way of operating. Benefits are those positive elements that are not only to be held up in a positive way, but that the structure will support in living strongly. Barriers are those challenges, concerns and downsides that need to be avoided in the new structure.
- Attendees broke into groups to develop benefits and barriers. Results were as follows:

**Group 1**:
*Benefits:*
1. Increased effective input from the community
2. New energy, creativity and ideas
3. Have the right expertise around the table
4. Flexibility (less prescriptive)
5. Core group represents those who will be fully engaged, ready to do the work and trusted

*Barriers:*
1. Too prescriptive
2. Avoid one area dominating another area, e.g., care dominating prevention

**Group 2**:
*Benefits:* Repeat Group 1, #3
1. More comprehensive response to HIV
2. Minimizing duplicated services
3. Leverage resources effectively

*Barriers:*
1. Avoid over-representation
2. Lack of consumer-provider balance
3. Increased informational learning curve for all concerned
4. Increased commitment to master information necessary to participate effectively

**Group 3**:
*Benefits:*
1. Ability for non-members to be heard
2. Mentorship
3. Decisions are grounded in the big picture or guiding principles
4. Open to all possibilities concerning structure
5. Process is well-documented
6. Self-management of emotions and a willingness to operate with the greater good as a priority

*Barriers:*
1. Assumption that community expertise equates to an inability to be skillful in technical areas
2. Planning process is not dictated solely by funders

**Group 4**:
*Benefits:*
1. Leverage resources more effectively
2. Opportunity to engage populations that have been left out
3. Better ability to implement NHAS
4. Encourage exchange of thoughts and ideas between care and prevention
5. More unified voice with everyone at the table
6. More evidence-based interventions

*Barriers:*

1. Fear of losing outreach to the HIV- high-risk population
2. Behavioral interventions may have a lower priority
3. Providers will need to adapt to a new reality
4. Health Education/Risk Reduction (HE/RR) is no longer the focus
5. Acknowledging different levels of trust among parties currently at the table

**Group 5**:
*Benefits:* Repeat Group 4, #1 and #4
*Barriers:*
1. Different regulatory requirements
2. Different local, state and federal governing bodies
3. Attendance

**Group 6**:
*Benefits:*
1. Getting a good vision includes consumers
2. Ensure Department of Public Social Services (DPSS) is at table (Addition to Group 1, #3)
3. Current Ordinance already gives flexibility to integrate
4. Learning experience that requires we check our egos at the door

*Barriers:*
1. Getting housing to be an essential part of care
2. Getting stuck on the process as opposed to achieving the goals
3. Not enough information on the process makes people fearful
4. Do not know who the consumers will be on the prevention side

**Group 7**:
*Benefits:*
1. Opportunity to design the ideal structure, define the outcomes we want and work from there

*Barriers:*
1. Avoid the tendency to simply take what currently exists and smush it together
2. Ensuring that the planning body remains independent of the health department

**Group 8**:
*Benefits:*
1. Increased accountability
2. Equality
3. Ability to migrate into a managed care environment
4. Unity provokes synergy

*Barriers:* Already reported by other groups

**Group 9**:
*Benefits:* Repeat Group 7, #1
*Barriers:* Repeat Group 7, #1

**Group 10**:
*Benefits:* Repeat Group 4, #1; Group 8, #4
*Barriers:* Repeat Group 5, #1
1. Demands and realities in this environment outpace the planning process and the challenge is whether we continue in this vein or change

**11. STRUCTURE AND NEEDS**:

**A. Who's at the Table?** Ms. Burbie asked attendees for lists of stakeholders needed at the table. Lists submitted were:

- Executive Directors and executive leadership, affiliated and nonaffiliated consumers, service providers, data and epidemiology people, high-risk HIV- consumers, broader definition of consumer, neutral facilitator and space
- Consumers (all aspects), housing experts, Department of Public Social Services (DPSS), substance abuse, STDs, key populations (prevention), current stakeholders, State of California, youth (or spokesperson for youth)
- Needle exchange, DHSP, mental health, substance abuse, housing, community activists/social justice work, doctors/doctor associations, Department of Health Services (DHS)/managed care, DPSS, case managers, Medi-

Cal/Medicare, prison reform, Kaiser, Federally Qualified Health Center (FQHC), United American Indian Involvement (UAII), mental health association, change agents

- Black – MSM; Latino – MSM; Native Americans; transgender people; youth; representatives from epidemiology, DHSP, STDs, mental health; three highest impacted cities; scientific experts; medical providers; housing; jails; faith-based
- Consumers; care providers (medical and nonmedical); housing providers; prevention providers/testing; municipalities (cities and counties); Departments of Public Health (DPH), Mental Health (DMH), Health Services (DHS) and Housing and Urban Development (HUD – local); DHSP; private enterprises (bath houses, condom manufacturers); community clinics (Community Clinic Association of Los Angeles County, CCALAC)
- People under 30 years old; people over 45 years old; all races/ethnicities; school sector/system; mental health, substance use; housing; STDs/TB/Hepatitis; tech savy; clinicians; DPSS; consumers of both prevention and care services; all RW Parts (A, B, C, etc.); researchers; capacity building providers; Medi-Cal; political leaders (senators, Congress, etc.)
- Consumers/HIV+ people, government agencies, researchers, HIV specialists, housing, substance abuse, mental health, faith-based communities, communities of color, women, different age groups, social workers/case managers, STD experts, managed care experts, health plans, attractive (per Mike Johnson), medical providers
- Veterans Administration (VA), RW Parts, post-incarcerated, LGBT, social services, HOPWA, DPSS, Medi-Cal, LA Care, HealthNet, Kaiser, consumers, providers, youth of color, DPH, DHS

**B. Scope of Authority/Responsibility**: This item was postponed.

**C. Membership Structure**: This item was postponed.

**13. NEXT STEPS**:

**A. Define Process for Implementation**:

- Ms. Burbie offered two options for a work group to begin the detailed work of envisioning and proposing the way forward for the unified body such as its operating mode and structure. One option is to expand the responsibilities of the current joint Comprehensive HIV Planning Task Force (CHP TF). The other option is to form an entirely new group.
- Mr. Gutierrez noted the current CHP TF has been focused on developing the joint Comprehensive HIV Plan (CHP).
- Mr. Rivas asked about CHP TF attendance. Mr. Gutierrez said it has ranged from about 15 to a handful.
- Mr. Vincent-Jones added Commission task forces do not do formal votes and membership is open to anyone who requests it. Meetings are also open to the public and anyone can ask to be on the mailing list.
- He continued that the CHP TF expects to finish the CHP by November so this would be a good time for a new task.
- It was suggested a new group could add new energy and signal a new beginning, but Mr. Gutierrez noted anyone can join the CHP TF which already has a group of people with a commitment to and history of creating a combined Commission-PPC effort. There is also a challenge in bringing new people to the table so many will be the same people.
- Mr. Fox felt creating new groups in general add beaurocracy. Using the CHP TF would improve efficiency.
- Ms. Rumanes suggested Commission leadership and PPC Community Co-Chairs identify a good core group while not limiting membership. She noted Mr. Brown emphasized the commitment and expertise needed to be effective.
- Mr. Land suggested using the CHP TF, but allowing it to adapt with those no longer interested leaving and new joining.
- Mr. Vincent-Jones recalled today's discussions about trust. The CHP TF has developed a high level of trust and a strong working relationship focused on integration in the past two- and a-half years. He felt that astounding with the difficult challenges in understanding each other's perspectives even when one might disagree. He wanted to build on that.
- ➲ Agreed to expand charge of the current CHP TF with augmented representation 38 to 6.
- ➲ CHP TF volunteers: Mr. Brown, Mr. Chud, Mr. Chadra, Ms. Enfield, Ms. Escobedo, Ms. Forrest, Mr. Fox, Ms. Granados, M. Green, J. Green, Mr. Gutierrez, Mr. Kelly, Mr. King, Mr. Klipp, Mr. Kochems, Mr. Land, Ms. León, Mr. Liso, Mr. Martinez, Mr. Rivas, Mr. Rosales, M. Smith, Mr. Talley, Ms. Tweddell, Mr. Vega-Matos, Ms. Washington-Hendricks

**B. What Questions Need to be Asked/Answered?** This item was postponed.

**C. Timeline**: This item was postponed.

**14. SUMMARY AND CLOSING**: Ms. Burbie thanked the group for their work. She noted tangible results of the meeting will be observable in continued attention to the benefits and barriers identified and in those volunteering to serve on the CHP TF.

**15. ANNOUNCEMENTS**: There were no announcements.

**16**. **ADJOURNMENT**: Mr. Johnson adjourned the meeting at 4:00 pm.

**A. Roll Call** (**Present)**:

- *Commission*: Bailey, Barrit, Branchick, Brown, Espinoza, Fox*, Frye, J. Green, James, Johnson, Kelly, Kiburi, Kochems, Land, Liso/Chud, Mendia, Palmeros, Pérez, Rios/Goddard, Rivera, Vega-Matos, Washington-Hendricks
- *PPC*: Carlos, Enfield, Fox*, Granados, M. Green, Gutierrez, King, Rosales, Rumanes, M. Smith, T. Smith, Topete

| **MOTION AND VOTING SUMMARY** | | |
|---|---|---|
| **MOTION 1**: Approve the Agenda Order. | ***Passed by Consensus*** | **MOTION PASSED** |